DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01			COMPLETED	
	<b>∥</b> 155459 <b> </b>		B. WIN			05/09/2	011
			D. 11111		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF P	PROVIDER OR SUPPLIER				16TH ST		
HICKOR	Y CREEK AT NEW (	CASTLE			ASTLE, IN47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0000							
	A Life Safety Co	de Recertification and	K(	0000			
	State Licensure S	Survey was conducted by					
	the Indiana State	Department of Health in					
		42 CFR 483.70(a).					
	Survey Date: 05	/09/11					
	Facility Nl	000241					
	Facility Number:						
	Provider Number						
	AIM Number: 1	00286550					
	Surveyor: Mark	Bugni, Life Safety Code					
	Specialist						
	At this Life Safet	ty Code survey, Hickory					
	Creek at New Ca	stle was found not in					
	compliance with	Requirements for					
	-	Medicare/Medicaid, 42					
	•	3.70(a), Life Safety from					
	-	· ·					
		edition of the National					
		ssociation (NFPA) 101,					
	Life Safety Code	(LSC), Chapter 19,					
	Existing Health (	Care Occupancies and					
	410 IAC 16.2.	_					
	This one story fac	cility was determined to					
	_	2) construction and fully					
		-					
	-	facility has a fire alarm					
	-	ke detection in the					
	corridors, spaces	open to the corridors,					
	and single station	smoke detection in all					
	_	rooms. The facility has					
					l		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CBQJ21

Facility ID:

000341

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MI	ULTIPLE CO	NSTRUCTION 01	(X3) DATE S COMPL		
155459		A. BUII		01	05/09/2		
			B. WIN	_	DDRESS, CITY, STATE, ZIP CODE		_
NAME OF P	ROVIDER OR SUPPLIER			901 N 1			
	Y CREEK AT NEW				ASTLE, IN47362		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		E	COMPLETION DATE
IAG		and had a census of 30 at	+	IAG			DATE
	the time of this v						
	the time of this v	1511.					
		Robert Booher, REHS, Life ist-Medical Surveyor on					
	•	nd not in compliance with the alatory requirements as lowing					
K0029 SS=F	fire-rated doors) of extinguishing system and/or 19.3.5.4 properties of the provestinguishing system are separated from resisting partitions self-closing and not protective plates the from the bottom of 19.3.2.1  Based on observations	em option is used, the areas on other spaces by smoke and doors. Doors are on-rated or field-applied that do not exceed 48 inches the door are permitted.	KO	0029	CORRECTION: OUR FACILI		05/27/2011
	and kitchen, were resistant self clos practice could affacility.  Findings include  Based on observa a tour of the facil 11:00 a.m. with the	such as a laundry room e provided with a smoke sing door. This deficient fect all residents in the  ation on 05/09/11 during lity from 8:35 a.m. to	IS LICENSED FOR 36 BEDSThi Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plar of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plar of Correction is submitted to mee requirements established by stat and federal law. Hickory Creek a New Castle desires this Plan of		s the nce  Plan sion at Plan meet state ek at of the		

000341

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3			(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	LDING	01	COMPL	ETED
		155459				05/09/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	8					
		0.4.071.5		901 N 1			
HICKOR	Y CREEK AT NEW	CASILE		NEW C	ASTLE, IN47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	room doors faile	d to self close and latch	İ		the policy of Hickory Creek a	tNew	
	in the door frame	es leaving a one inch to			Castle to assure that the doo	orsare	
		This was verified by			automatically self-closing		
		_			accordingto NFPA 101 Life S		
		ervisor at the time of			Code 19.3.2.1 How will corre		
	observations.				action be taken? SafeCare,		
					fire alarm vendor, is schedule		
	3.1-19(b)				replace the automatic self clo door to the kitchen on 5-24-	-	
					maintenance has already	ITanu	
					replaced the door closure to	the	
					clean laundry room .5-24-11		
					will Hickory Creek at New Co		
					identify others affected by th		
					alleged deficient		
					practice? Although all reside	nts	
					could have beenaversely		
					affected, no resident was		
					harmedas a result of this def		
					practice. What measures wi		
					Hickory Creek at New Castle		
					into place so the alleged def		
					practice will not recur? The Maintenance Director willche		
					monthly, during	CK	
					routinepreventative maintena	ance	
					rounds to see that all doors		
					latch and/or self-close into the		
					door frames. These checks	-	
					be documented on the		
					preventativemaintenance for	m	
					and turned into theAdministr		
					for review. How will Hickory		
					Creek at New Castle monito	r its	
					corrective actions? The		
					Administrator will monitormo	nthly	
					by review of the	2000	
					routinepreventative maintena		
					roundsform and routine roun assurethat all doors latch an		
					self- close into the door fram		
					and meet the applicable		
	I		1		and model and applicable		

	AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155459		(X2) MI A. BUII B. WIN	LDING	01	(X3) DATE : COMPL 05/09/2	ETED
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE		•	901 N 1	ADDRESS, CITY, STATE, ZIP CODE 16TH ST ASTLE, IN47362			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K0052 SS=F	installed, tested, a accordance with N Code and NFPA 7 approved mainten complying with ap NFPA 70 and 72. Based on observate facility failed to paystem trouble situate to be heard by fawith NFPA 72 the Code. NFPA 72, signals to be locallikely to be heard requires fire alarmand trouble signate descriptively annual practice could after and visitors.  Findings include  Based on an obsettesting with the mon 05/09/11 at 10 automatic dialeratrouble from phominutes, there we initiated at the differ alarm systems.	IFPA 70 National Electrical 2. The system has an ance and testing program plicable requirements of 9.6.1.4 ation and interview, the provide a fire alarm gnal in a location likely cility staff in accordance e National Fire Alarm 1-5.4.6 requires trouble ated in an area where it is d. NFPA 72, 1-5.4.4 ms, supervisory signals, als to be distinctive and aunciated. This deficient fect all residents, staff	K	0052	requirements of the Life Safe Code. Completion Date: Ma 2011  CORRECTION: THIS FACIL IS LICENSED FOR 36 BEDS.This Plan of Correction constitutes the written allegated of compliance for the deficiencited. However, submission this Plan of Correction is not admission that a deficiency or that one was cited correct. This Plan of Correction is submitted to meet requirement established by state and fed law. Hickory Creek at New Composition of Compliance. Compliance is effective on 5-10-11. K 052 It is the policy Hickory Creek atNew Castle assure that thefire alarm systian is installed with approved components, devicesor equipment and meets therequirements of NFPA 72 National Fire Alarm Code, to provide effective warning of any part of the building. How corrective action be taken? SafeCare, our fire alarm vendor, sent technician 5-10-who repaireddigital dialer bos connected to thephone lines.	LITY In tion ncies of an exists ly. Ents eral castle on to exp of to tem  fire in / will  11 x	05/10/2011

000341

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/27/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE SURVEY  COMPLETED	
AND PLAN	OF CORRECTION	155459	A. BUILDING	01	05/09/2011
		100400	B. WING	DET A DEDECK CHEV CHATE AID CODE	00/00/2011
NAME OF F	PROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE    N 16TH ST	
HICKOR'	Y CREEK AT NEW	CASTLE		W CASTLE, IN47362	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFI	CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG		DATE
	_	ervisor at the time of fire		ensure that the fire alarmpar box would signal trouble ale	
	alarm system tes	ting.		there was a disruption of the	•
				phoneservice to the alarm	
	3.1-19(b)			system. How will Hickory Cr	eek at
				New Castle identify others	
				affected by the alleged defic	•
				practice? Although the poter existed, noresidents were	Illai
				adversely affectedby this alle	eged
				deficient practice. What	
				measures will Hickory Creek	I
				New Castle put into place so alleged deficient practice wil	
				recur? During the monthly	•
				drill tests,the Maintenance	
				Director willcheck the digita	
				dialer box to assurethat it is	
				working properly. This chec be documented on the fire d	•
				reportwhich will be turned in	I
				Administrator. How will Hick	I
				Creek at New Castle monito	ror its
				corrective actions? The faci	, I
				Administrator, monthly, willre	
				fire drill reports to verify that thedialer was checked and is	
				working properlyand meets t	•
				applicablerequirements of th	
				SafetyCode. Completion	
170062	Dogwinod automt	io apripklar avatares ere		Date: May 10, 2011	
K0062 SS=E		ic sprinkler systems are tained in reliable operating			
33-E		inspected and tested			
	periodically. 19.	7.6, 4.6.12, NFPA 13, NFPA			
	25, 9.7.5			000000000000000000000000000000000000000	( TT) (
		ation and interview, the	K0062	CORRECTION: THIS FACI	05/2//2011
	1 *	ensure a complete		IS LICENSED FOR 36 BEDS This Plan of Correction constitution	
	automatic sprink	ler system was		the written	100
	maintained in acc	cordance with NFPA 13,		allegation of compliance for the	e
				deficiencies	1

000341

STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CON	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	ì	01	COMPL	ETED
	155459		B. WING			05/09/2	011
NAME OF I	PROVIDER OR SUPPLIER		STR	REET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER		90	1 N 16	STH ST		
	Y CREEK AT NEW (			W CA	ASTLE, IN47362		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREF	- 1	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAC	j		.1 .	DATE
		or the Installation of			cited. However, submission of Plan of	this	
		ns. NFPA 13, 6-1.1.5			Correction is not an admission	that a	
	• •	r piping or hangers shall			deficiency	mai a	
	not be used to su	pport nonsystem			exists or that one was cited corn	rectly.	
	components. The	is deficient practice could			This Plan	,	
	affect 18 resident	ts who reside in the North			of Correction is submitted to m	eet	
	Hall.				requirements		
					established by state and federal	law.	
	Findings include	<u>.</u>					
	1 manigs merade	•			Hickory Creek at New Castle d this Plan	esires	
	Dagad on alegamy	ation on 05/00/11 during			of Correction to be considered	the	
		ation on 05/09/11 during			facility's	uic	
		5 p.m. to 11:00 a.m. with			Allegation of Compliance.		
		supervisor, the boiler			Compliance is		
		eas where electrical			effective on 5-27-11.		
	conduit and telep	shone lines were tied to					
	the sprinkler pipi	ng with zip strip plastic			K 062		
	ties. This was ve	erified by the					
	maintenance sup	ervisor at the time of			It is the policy of Hickory Cree New Castle to ensure that the	k at	
	observation.				automatic		
					sprinkler system is maintained	in	
	3.1-19(b)				accor-		
	3.1-17(0)				dance with requirements of NF	PA 13,	
					1999 Standard for the Installati	on of	
					Sprinkler Systems.		
					How will corrective action be to	aken?	
					M. 1		
					Maintenance shall have all elec	итса	
					and telephone lines that were a	ffixed	
					to	iiiACU	
					sprinkler piping with zip strip p	olastic	
					ties		
					in the boiler room removed by		
					5-27-11.		
				[			

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES  OF CORRECTION	IDENTIFICATION NUMBER:  155459	(X2) MULTIPLE C  A. BUILDING  B. WING	01	COMPLETED 05/09/2011
	ROVIDER OR SUPPLIER		STREET 901 N	ADDRESS, CITY, STATE, ZIP CODE  16TH ST  CASTLE, IN47362	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				How will Hickory Creek at Ne Castle identify others affected the alleged deficient practice?	
				Although the potential, existed residents were adversely affected by this alleged deficient practice.	
				What measures will Hickory C at New Castle put into place so alleged deficient practice will recur?	o the
				Maintenance will check any further updates in wiring noting that all changes comply with the requirements of NFPA 13, 199 Standard for the Installation of Sprinkler Systems. This check will be completed before the contractor leaves the property and noted on the work order or invoice.	9
				How will Hickory Creek at New Castle monitor its corrective actions?  After any future repairs the Administrator and Maintenance will inspect the area to determine that no wiring was attached to the sprinkler piping.	e

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
	155459		B. WIN		-	05/09/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF F	KOVIDER OR SUPPLIER			901 N 1	16TH ST		
	Y CREEK AT NEW				ASTLE, IN47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					Completion Date:		
					Completion Bute.		
					May 27, 2011		
K0144		spected weekly and					
SS=F		ad for 30 minutes per					
	month in accordar 3.4.4.1.	ice with NFPA 99.					
		ation and interview, the	l KC	144	CORRECTED: THIS FACILI	TY	06/07/2011
		ensure 1 of 1 emergency	120		IS LICENSED FOR 36 BEDS		50/07/2011
	_	equipped with a remote			Plan of Correction constitutes	sthe	
	_	ch in a location remote			written allegation of	_	
	-	ncy generator. LSC			compliancefor the deficiencie cited. However, submission o		
	_				plan ofcorrection is not an	1 1110	
	•	emergency generators			admission thata deficiency ex	xists	
		to emergency lighting			or that one wascited correctl	ly.	
	_	installed, tested and			This Plan ofCorrection is		
		cordance with NFPA 110,			submitted to meet therequirements established	hv	
		ergency and Standby			stateand federal law. Hickory		
		NFPA 110, 1999 edition,			Creek at New Castledesires		
	•	Level II installations shall			Plan of Correction to be		
		anual stop station of a			considered the facility'sAllegation of Compliance.Compliance is		
		break-glass station			effective6-07-11. K 144 lt is		
		e on the premises where			policy of Hickory Creek atNe		
		is located outside the			Castle to assure that the		
	_	37, Standard for the			generatormeets the requirem	ients	
	Installation and U	•			of NFPA 110, Standard for Emergency and Standby Pov	<i></i> ver	
	_	ines and Gas Turbines,			Systems, NFPA 110, 1999		
		8-2.2(c) requires engines			editionto ensure generator to	be	
	of 100 horsepow	er or more have			equipped witha remote manu		
	provision for the	shutting down the engine			stop switch in a location remo	ote	
	at the engine and	from a remote location.			generator. How will corrective	e	
	This deficient pra	actice could affect all			action be taken? Contracted		
	residents in the fa	acility.			generator vendor to installa		
					remote manual stop switch ir	ı a	
					location remote from the		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER:	(A2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY  COMPLETED
ANDILAN	or connection	155459	1	LDING	01	05/09/2011
		100100	B. WIN	_		03/03/2011
NAME OF F	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
חוראטטי	Y CREEK AT NEW	CARTIE		901 N 1	6TH ST ASTLE, IN47362	
				<u> </u>	MOTLE, 11141 302	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG			+	IAG		5.112
	Based on observe the maintenance the emergency go stop switch mour of the machine w switch was locate interview with the on 05/09/11 at 10 set was installed remote stop switch	ation on 05/09/11 with supervisor at 10:20 a.m., enerator had a manual nted directly on the front where the gauges and start			emergency generator. How Hickory Creek at New Castle identify others affected by the alleged deficient practice? The process was done throughout nursing home as all resident were affected. What measus will Hickory Creek at New Caput into place so the alleged deficient practice will not record in the event that any future updates with new generators made, Hickory Creek at New Castle willmake certain that changes will comply with the requirements of NFPA 110, Standard for Emergency and Standby Power Systems, NF 110, 1999 edition. How will Hickory Creek at New Castle monitor its corrective actions? The Maintenance Director willmonitor any addition of new generatorat the facility The facility Administrator will the over all responsibility to ensure that anychange will comply with the require-men NFPA 110, Standard for Emergency and Standby Posystems, NFPA 110, 1999 edition Completion Date: Jul 07, 2011	will e e his utthe s res astle ur? are any e tion y have ts of wer